Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CHANNELVIEW MEDICAL CENTER
3033 FANNIN ST
HOUSTON TX 77004-3258

Respondent Name
Zurich American Insurance Co

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-13-2647-01

MFDR Date Received
June 17, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The office visit notes and well ac TWCC73 were included in the reconsideration dated 5/9/13 yet the bill was denied again with the same explanation."

Amount in Dispute: $180.10

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Fee schedule Team has indicated that no further payment should be allowed at this time."

Response Submitted by: Gallagher Basset Services, Inc. 16414 San Pedro Ave. Suite 950, San Antonio, TX 78232

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 19, 2013	Professional Services	$180.10	$118.65

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the requirements for medial bill submission by health care providers.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. 28 Texas Administrative Code §129.5 sets out procedures for submitting reports.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION
   - BL – THIS BILL IS A RECONSIDERATION OF A PREVIOUSLY REVIEWED BILL.

Issues

1. Did the respondent support the insurance carrier's reason for denying disputed services?
2. What is the applicable rule for determining reimbursement for the disputed service?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.20(b)(1) states, in pertinent part, "for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;… and other payment policies in effect on the date a service is provided…" The insurance carrier denied code 99213 and 99080 with reason code, 16 – "CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. The submitted code 99080 does require a modifier per 28 Texas Administrative Code §129.5 therefore, the carriers' denial is supported. No reimbursement recommended. Review of submitted information finds the carriers' denial is not supported for code 99213. Therefore, this line will be reviewed per applicable rules and guidelines.
2. 28 Texas Administrative Code §134.203(c) is the applicable division fee schedule for calculation of the maximum allowable reimbursement for the services in dispute. For services in 2013, the maximum allowable reimbursement = (TDI-DWC Conversion Factor / Medicare CONV FACT) x Non Facility Price or;

Code	MAR Calculation	Units	Allowable
99213	(55.3 / 34.023) x 73.00	1	$118.65
99080	Not supported	1	$0.00
		Total	$118.65

3. The total allowable for the disputed services is $118.65. This amount less the amount paid by the carrier of $0.00 leaves the requestor due $118.65.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $ 118.65.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $118.65 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 25, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee***

Dispute Resolution Findings and Decision together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.